

# **NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES**

## **OFFICE OF MINORITY HEALTH**

### **The Health of Minorities in New Jersey**

## **SUMMIT RECOMMENDATIONS REPORT**

**Prepared by: The Office of Minority Health  
Advisory Commission**

**May, 2000**



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**Christine Todd Whitman**  
*Governor*

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*Commissioner*

## INTRODUCTION

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In September of 1999, the Office of Minority Health (OMH) Advisory Commission in conjunction with the New Jersey Department of Health and Senior Services (DHSS) Office of Minority Health, launched a two-part summit series on minority health issues. The first summit, “The Health of Minorities in New Jersey: Part I-The Black Experience,” was the vision of the OMH Advisory Commission and succeeded in breaking new ground in developing a comprehensive agenda to improve the health status of Blacks living in New Jersey. The Office of Minority Health Advisory Commission established and worked with a dedicated sub-committee of health care leaders who were instrumental in the planning and success of the summit program.

Addressing the myriad issues associated with eliminating disparities in minority health was the primary goal of the summit. The more than two hundred summit participants who gathered for this historical meeting worked hard to forge an agenda that recognized the roles that health care providers, elected officials, government and community leaders could assume in changing the face of disparities. The Summit Planning Committee was instrumental in the genesis of the second phase of the minority health summit, Part II - “The Latino Experience.” It will occur on June 2nd and 3rd, 2000.

While New Jersey is not alone in facing disparities in the health status of minorities, this summit demonstrated New Jersey’s leadership role in raising levels of awareness, engaging stakeholders, and identifying new and best practices to break the long standing cycle of disparities in minority health. This New Jersey initiative reflects both the national and state Healthy People 2010 planning agenda to address over-all health status and to eliminate health disparities.

In the earliest planning stages, the OMH Advisory Commission recognized that addressing disparities in minority health was a formidable challenge that required the involvement of top decision makers in government, the health care industry, academia and the state’s diverse community leaders, including faith based groups, community organizations, and civil rights groups. The Summit planners agreed that the challenge of improving minority health was far too great of a problem for any one state entity or group to solve, therefore a broad based coalition was needed to make significant progress in implementing a minority health agenda.

Funding from The Robert Wood Johnson Foundation and the New Jersey Department of Health and Senior Services provided support for the summit and its related activities. In addition, the Robert Wood Johnson Foundation hosted a special pre-summit kick-off breakfast for the state’s top health care executives. The breakfast drew nearly 100 of New Jersey’s health decision-makers who participated in a candid discussion with Commissioner Christine Grant about ways to improve the health of minorities. The breakfast discussion informed the final planning stages of the summit and encouraged broad based participation from the health community. Funding also made possible a 30-minute video, available to community-based organizations and other interested parties on request, that provides a snapshot of summit activities.

At the summit, participants focused on five major areas for discussion and development of policy recommendations and strategies. Specifically these areas were: data collection; cultural competency; over-all health disparities; HIV/AIDS; and increasing the visibility of the Office of Minority Health. The broad-based recommendations in this report (Overall Recommendation) were developed and agreed upon by all summit participants. Through small group break out discussions, participants crafted specific recommendations in the topic areas. In the large group discussion that followed consensus was reached on recommendations presented by the small groups. Opportunity was provided for discussion, questions and debate in the large group discussion. Only recommendations that had the full support of summit participants appear in this report.

In addition to the over-all recommendations, each of the recommendations in this report is followed by specific action steps that can be implemented over the next two years. While many of the action steps reflect suggestions made in the small and large group discussions, the summit planning committee drafted and finalized the action steps after the summit. The Summit Planning Committee reviewed and supported all of the action steps that appear in this document. This report is viewed as an important opportunity for collaborative action, local initiatives and creative community-based leadership to address these issues.

The over-all recommendations and action steps include a listing of responsible parties. While the Department of Health and Senior Services has a role in implementing all the recommended action steps, other state agencies, health care provider and community groups are expected to join in partnership with DHSS in making this action plan a reality.

The recommendations and action steps in this report do not necessarily reflect the point of view of the Department of Health and Senior Services. Nevertheless, the OMH Advisory Commission looks forward to continued cooperation in its work with DHSS.

The planners of this summit are eager for this report to be embraced by all New Jerseyans. While this report represents an important first step for establishing a framework for action, summit planners recognize that health experts and community advocates must remain diligent in mapping out new ideas and seeking additional resources to alter health care trends. The collective vision and renewed commitment to minority health that emanated from this summit are already important New Jersey landmarks.

## DATA - WHAT WE KNOW

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Traditionally, the Department of Health and Senior Services has had more data on white and black races than on other racial groups or on Hispanics. However, some of the data on the black population is not very precise and some data sets are only available on the state level. Major data sets available on the state level for the black population include:

- ◆ resident births and deaths,
- ◆ fetal deaths,
- ◆ estimates from the Behavioral Risk Factor Surveillance System,
- ◆ HIV/AIDS Registry,
- ◆ Cancer Registry,
- ◆ estimates on prevalence of tobacco, drug and alcohol use among high school students (from the Department of Law and Public Safety) and middle school students (Department of Health and Senior Services),
- ◆ estimates of health insurance coverage from the Current Population Survey,
- ◆ hospital discharge files, and
- ◆ induced termination of pregnancy.

Of these data sets, only birth and death files, fetal deaths, AIDS and Cancer incidence and hospital discharge files are sufficiently complete and large enough to provide data on the black population for counties and municipalities. Even where the data exist for local areas, the numbers may be too small to be meaningful and cannot be published due to confidentiality requirements.

A number of programs have data on clients served, such as WIC and the Lead Screening Program, and other data sets are under development that may provide data by race, such as the Minimum Data Set in the Division of Long Term Care Systems Development. A departmental Health Information Steering Committee is active in identifying opportunities related to the standardization and coordination of data collection, analysis and dissemination.

## **DATA - WHAT WE NEED TO DO**

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### **I. OVERALL RECOMMENDATIONS**

- ◆ Improve data collection by race and ethnicity.
- ◆ Develop language and culturally appropriate survey instruments to collect community based health data. Members of the community should be trained to use these instruments.
- ◆ Establish a statewide information center to facilitate the sharing of race/ethnic specific data; the data should be user-friendly and easily accessible by an 800 number and through the Internet.
- ◆ Establish a consortium of government, health care industry and community partners to:
  - ! Make decisions on important data elements to enhance understanding of health status of minorities;
  - ! Determine standardized definitions and classifications for race and ethnicity.
- ◆ Develop partnerships with local organizations that have gained the trust of immigrant and other minority populations in order to increase understanding of the purpose of data collection.
- ◆ Improve and expand the race/ethnic specificity in the collection, analysis and reporting of data on people of African descent in New Jersey.

### **II. ACTION STEPS**

- ◆ Assess current data set requirements; collection tools; and methodologies for the collection, reporting and analysis of race/ethnic specific information and provide a baseline report on the specific issues that must be addressed to improve the data collection for minority health status.
- ◆ Assess current methodologies used for data collection and make specific recommendations for improvement.
- ◆ Establish a diverse and broad based advisory committee with appropriate state authority to make recommendations to the NJDHSS for improving the collection, reporting and analysis of data to more accurately reflect the health status and profile of New Jersey's minority populations.
- ◆ Educate and train local communities about the importance of accurate data collection and its use in developing programs and allocating resources for improving the health status of minorities.

- ◆ Develop a Minority Health Resource Center within the State Office of Minority Health which will serve as a repository for all minority health data in the state.

**Primary Responsible Parties:**

- ◆ New Jersey Department of Health and Senior Services/Center for Health Statistics
- ◆ New Jersey Department of Health and Senior Services/Office of Minority Health

## OVERALL HEALTH DISPARITIES - WHAT WE KNOW

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- ◆ A Black male born in 1994 - 1996 could expect to live 65 years, on average, while a white male had a life expectancy of 74 years. A Black female could expect to live to age 73, while a white female had an 80-year life expectancy.
- ◆ The Black homicide death rate (19.6)\* in 1996 was more than seven times the rate for whites (2.6). Most deaths involved the use of firearms.
- ◆ In 1996, the Black death rate from unintentional injuries was nearly twice the white rate - - 35.9 for African-Americans compared with 21.5 for whites. The most common causes of injury-related death in African-Americans were motor vehicle-related injuries and drug overdoses.
- ◆ Although infant mortality rates have been declining in general, Black infants are more than three times as likely as white babies to die in the first year of life. In 1996, the Black, non-Hispanic, infant mortality rate was 15.1 deaths per 1,000 live births, compared with 4.4 for non-Hispanic whites.
- ◆ Black men were more than twice as likely to die of prostate cancer (35.9) than were white men (14.2) in 1996. Prostate cancer incidence was much higher in Black men (196.8) than white men (124.1) in 1996.
- ◆ In 1996, Black women were twice as likely (4.9) as white women (2.2) to die from cervical cancer, despite having similar rates of Pap testing used to diagnose this cancer.
- ◆ Although Black women were less likely to develop breast cancer, they were more likely than white women to die of the disease in 1996. (29.5 for Blacks vs. 21.4 for whites)
- ◆ The Black death rate for diabetes (35.9) was two-and-a-half times the white rate (14.6) in 1996.
- ◆ The Black death rate due to stroke (37.7) was nearly 80 percent higher than the white (21.2) rate in 1996.
- ◆ Heart disease death rates were more than 20 percent higher for Blacks (157.3) than for whites (127.5) in 1996.
- ◆ Twenty-two percent of Blacks under age 65 did not have health insurance coverage in 1997, compared with 14 percent of whites.

\*All numbers in brackets are per 100,000 age-adjusted population.

# **DISPARITIES - WHAT WE NEED TO DO**

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## **I. OVERALL RECOMMENDATIONS**

- ◆ Facilitate the exchange of best practices for addressing health disparities among organizations, providers, community groups and agencies. Widely disseminate information regarding disparity issues and effective solutions.
- ◆ Forge and reinforce collaborative efforts to build partnerships with agencies and community groups.
- ◆ Develop and reinforce multidisciplinary approaches to disease management.
- ◆ Replicate programs that modify behavior across a broad scope of health issues; institute these lessons in school curriculums starting at the elementary levels.
- ◆ Involve and use the community more effectively. Include minorities in key roles (i.e. policy and decision making) where significant minority input may be missing and needed (i.e. hospital boards, IRB boards, providers/managers/administrators).
- ◆ Develop strategies to involve Blacks in research and clinical trials.
- ◆ Legislate and monitor a more effective allocation or redirection of resources to target minority health care issues. Increase the budget for this effort in the following ways:
  - ! direct tobacco dollars to minority health;
  - ! provide incentives and encourage pharmaceutical companies to contribute resources;
  - ! provide a long term funding to sustain programs as well as technical assistance;
  - ! ensure that funds reach the intended communities.

## **II. ACTION STEPS**

- ◆ Increase awareness of disparities in health status by race/ethnicity in New Jersey.
- ◆ Develop and implement a statewide awareness and educational campaign to: 1) raise levels of information and awareness about minority health disparities; 2) promote changes in consumer behaviors to foster best health practices and improve quality of life; and 3) encourage and promote culturally based and culturally competent health care practices and interventions by health care providers.
- ◆ Target and allocate resources in all future budgets to establish a technical assistance and training program to enhance the infrastructure and effectiveness of community-based agencies/organizations that provide and/or promote sustained access to health care for minorities.



- ◆ Based on NJ 2010 goals, increase budget allocations to target programs that address eliminating disparities.
- ◆ Expand the use of current resources by:
  - ! enhancing the web site for the Office of Minority Health to include health resource information, data and personal health information;
  - ! publishing a best practice guide/report for eliminating disparities; and
  - ! facilitating greater utilization of minority and mainstream media to educate and report on minority health care issues.
- ◆ Develop leadership and promote inclusion of minorities in decision making and key positions in the health care industry and public arena through the establishment of a minority leadership mentoring and training program that includes incentives to organizations for aggressive and effective recruitment and retention of minorities in government and health care institutions.

**Primary Responsible Parties:**

- ◆ Office of the Governor
- ◆ New Jersey State Legislature
- ◆ New Jersey Department of Health and Senior Services
- ◆ Health Care Providers
- ◆ Community Organizations
- ◆ Media

## HIV/AIDS - WHAT WE KNOW

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- ◆ While Blacks make up 14.5 percent of the state's population, they account for 51 percent of the men (13,729 Black men) and 65 percent of the women (6,602 Black women) diagnosed with AIDS from the beginning of the epidemic through 1998.
- ◆ In 1998, Blacks represented 56 percent of the men (762 Black men) and 72 percent of all women (527 Black women) reported with AIDS.
- ◆ The Black death rate from HIV/AIDS (90.8 deaths per 100,000 age-adjusted population) was more than nine times the white rate (9.6) in 1996. On average, five people die of AIDS every day in New Jersey and three of the five are Black.

# **HIV/AIDS - WHAT WE NEED TO DO**

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## **I. OVERALL RECOMMENDATIONS**

- ◆ Strengthen educational initiatives on HIV/AIDS including school-based programs, community-based programs (including churches) and programs aimed at health care professionals. These educational initiatives should emphasize prevention strategies, and training for people on how to effectively interact with the health care system. These educational initiatives should be implemented universally.
- ◆ Develop a model of harm reduction that includes drug treatment on demand, needle exchange, and clean needle purchasing strategies.
- ◆ Develop culturally competent and accessible sources of care which specifically address the fear, suspicion, alienation, economic and transportation barriers faced by many at-risk patients. These sources of care should include school-based clinics, prisons and community-based clinics.
- ◆ Develop a strategy to change the “face of AIDS.” A compassion-based model that emphasizes the reality of AIDS affecting all communities - not just the poor, not just IV drug users, not just gay men, as it affects everyone.
- ◆ Establish an HIV/AIDS Ad-Hoc subcommittee to focus on the Summit’s recommendations.

## **II. ACTION STEPS**

- ◆ Increase public awareness activities about the HIV/AIDS epidemic in the African-American community through: 1) development of educational materials targeted to the adolescent population to promote early interventions for prevention; 2) distribution of multi-media materials/resources to grass roots organizations and training of a cadre of community-based educators to engage the community in discussions and actions to combat HIV/AIDS; and 3) work with a broad based coalition of faith organizations to develop church-based educational programs.
- ◆ Develop HIV/AIDS curriculum guidelines for all health professionals and schools of medicine, allied health, and nursing.
- ◆ Advocate for the implementation of a broad array of harm-reduction strategies that include mechanisms to make drug treatment more readily and easily accessible.
- ◆ Utilize epidemiologic and clinical research data to develop a position paper on needle exchange to be provided to political and community leaders.
- ◆ Utilize epidemiologic and clinical research data to develop a position paper on condom distribution in New Jersey jails and prisons.

**Primary Responsible Parties:**

- ◆ New Jersey Department of Health and Senior Services /Department of HIV/AIDS Prevention and Control
- ◆ New Jersey Department of Health and Senior Services/Office of Minority Health
- ◆ New Jersey Department of Education
- ◆ Health Care Professionals
- ◆ Community Organizations
- ◆ Academics

## CULTURAL COMPETENCY - WHAT WE KNOW

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There is a flurry of activity around the issue of cultural competency and how it should be integrated into an institution. In 1998, the Health Care Financing Administration proposed new regulations mandating states establish cultural competence guidelines for managed care plans and is currently exploring implementing cultural competency standards for Medicare. The New Jersey Department of Human Services recently completed a final draft of the Medicaid Managed Care Contract, which includes contract language regarding cultural competent requirements for providers.

The Department of Health and Senior Services has accomplished the following:

- ◆ Convened the Division of Family Health Services Diversity Team - March 1998
- ◆ Convened the Division of Family Health Services Planning/ Advisory Committee on Cultural Competence and Workplace Diversity – March 1998
- ◆ Convened the Cultural Competence Subcommittee of the Advisory Council on Black Infant Mortality – August 1998

The following problems, however, still persist:

- ◆ A lack of culturally competent programs/services act as a barrier to care/access for many minority populations.
- ◆ There is an inadequate representation of minorities in health care institutions/programs/ decision-making positions to thereby promote and foster an atmosphere and practice of culturally competent standards or to integrate such standards within an institution.

# **CULTURAL COMPETENCY - WHAT WE NEED TO DO**

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## **I. OVERALL RECOMMENDATIONS**

- ◆ Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operation, evaluation, and training as appropriate to ensure culturally competent care. This would include focus groups, community meetings, and trainers from the communities and community feedback loops.
- ◆ Require and arrange for on-going education and training for policy, administrative, clinical and support staff in culturally and linguistically competent service delivery, utilizing agreed upon curriculum guidelines which can be adapted to varying environments.
- ◆ Convene a planning/policy group to discuss the development and implementation of an agenda on cultural competency for the state of New Jersey. This should build on best practice standards, which have already been developed at the state and federal level.
- ◆ A consortium of organizations, providers and programs should be developed and utilized to provide cultural competency training, research, technical assistance and fund development.
- ◆ Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological, health seeking and utilization behaviors, and clinical outcome data for specific populations of African descent.

## **II. ACTION STEPS**

- ◆ Develop a departmental wide strategic plan to adapt/implement cultural competence standards in each division of DHSS, utilizing the standards developed by the United States Office of Minority Health. This includes training of all appropriate staff, allocation of sufficient resources for training and materials, and empowering the OMH Advisory Commission to provide oversight of the plan.
- ◆ Review, comment and make recommendations for changes and enforcement of relevant department policies, administrative codes and state statutes relating to cultural and linguistic competence.
- ◆ Include cultural competency guidelines/expectations in all Request For Proposals and monitor grantees in meeting cultural competency standards.
- ◆ Ensure compliance with cultural competence guidelines/standards among all health care insurers, providers and grantees that receive state contracts for providing any level of health care services to any minority groups/populations.

**Primary Responsible Parties:**

- ◆ Office of the Governor
- ◆ New Jersey State Legislature
- ◆ New Jersey Department of Health and Senior Services
- ◆ New Jersey Department of Human Services
- ◆ New Jersey Division of Medical Assistance and Health Services
- ◆ New Jersey Department of Banking & Insurance

## OFFICE OF MINORITY HEALTH - WHAT WE KNOW

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New Jersey has one of the longest standing Offices of Minority Health in the nation. Currently, there are 30 states with Offices of Minority Health, but few states have as long or as consistent a track record in a sustained effort to address minority health issues. Since its establishment in 1990, the NJDHSS, Office of Minority Health has provided leadership in developing activities to address persistent health disparities among all race/ethnic minorities. Specific activities of the NJDHSS, Office of Minority Health include, but are not limited to, the following:

- ◆ Promoting community health outreach and education through partnership with community-based organizations, including faith-based groups;
  - ◆ Assisting in developing policies to improve health care access and services for minority populations;
  - ◆ Assisting community-based organizations in identifying potential funding and other health resources;
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- ◆ Assisting in improving methods for collecting and reporting data on minority health;
  - ◆ Sponsoring annual Minority Health Month activities;
  - ◆ Assisting in developing effective outreach campaigns and public health initiatives;
  - ◆ Promoting advocacy and coalition building across state agencies that provide services to minority populations;
  - ◆ Supporting public and professional education on minority health issues.



# **OFFICE OF MINORITY HEALTH - WHAT WE NEED TO DO**

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## **I. OVERALL RECOMMENDATIONS**

- ◆ Increase legislative and regulatory visibility.
- ◆ Seek adequate state and private funding.
- ◆ Build partnerships across community-based organizations, various state and local systems.
- ◆ Develop an information clearinghouse which includes data collection by county.
- ◆ Develop a health disparities elimination plan.

## **II. ACTION STEPS**

- ◆ Design and advocate for the use of a health disparities impact statement that can be used for assessing the potential of all health related policies, statewide programs and legislative proposals in eliminating health disparities.
- ◆ Ensure an adequate budget and allocation of resources to the Office of Minority Health to support: 1) the oversight of implementation of the Summit recommendations and action steps; and 2) to fund specific initiatives to address health disparities, through a dedicated and sustained source of funding.
- ◆ Facilitate a mechanism to assess and report on progress made by the Office of Minority Health in engaging community participation and other vested parties in the plan to eliminate health disparities. A starting point could be regional follow-up meetings of the pre-summit focus and the summit breakout groups.

### **Primary Responsible Parties:**

- ◆ Office of the Governor
- ◆ New Jersey State Legislators
- ◆ New Jersey Department of Health and Senior Services
- ◆ New Jersey Department of Health and Senior Services/Office of Minority Health Advisory Commission

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